



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

ST. ANTHONY'S HOSPITAL  
PO BOX 950  
AMARILLO TX 79176-0001

#### **Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-97-0581-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Subclaimant asserts that it is entitled to payment from the carrier, for all three (3) dates of service, as the medical records show the length of stay was justified and medically necessary, and requests that the Commission issue an order accordingly. The Subclaimant also asserts that these charges for outpatient treatment were fair and reasonable."

**Amount in Dispute:** \$3,001.18

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "In conclusion it is the Fund's position that no additional reimbursement is due to the provider for the following reasons. The inpatient reimbursement should have been denied for no preauthorization..."

**Response Submitted by:** Texas Workers' Compensation Insurance Fund, PO Box 12029 Austin, Texas 78711

### ***SUMMARY OF FINDINGS***

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 1996 to March 1, 1996	Inpatient Hospital Services	\$3,001.18	\$0.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out

the reimbursement guidelines for the services in dispute.

3. Former Texas Administrative Code §133.304, effective February 20, 1992, 17 TexReg 1105, sets out the procedures for notice of medical payment dispute.
4. This request for medical fee dispute resolution was received by the Division on February 27, 1997.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - F – REIMBURSED IN ACCORDANCE WITH THE TEXAS HOSPITAL INPATIENT FEE GUIDELINE.
  - G – REIMBURSEMENT FOR THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE.

## **Findings**

1. The respondent's position statement asserts that "The inpatient reimbursement should have been denied for no preauthorization." Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee." No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment. The Division concludes that the respondent has not met the requirements of §408.027. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 TexReg 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 South Western Reporter Second 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 South Western Reporter Third 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 Texas Register 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
3. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. Review of the submitted documentation finds that:
  - The requestor's position statement asserts that "Subclaimant asserts that it is entitled to payment from the carrier, for all three (3) dates of service, as the medical records show the length of stay was justified and medically necessary, and requests that the Commission issue an order accordingly. The Subclaimant also asserts that these charges for outpatient treatment were fair and reasonable."
  - The requestor did not submit documentation to support that the charges were fair and reasonable.
  - Regardless of whether the hospital billed its usual and customary charges or whether the charges were comparable to charges billed by other hospitals for similar services, no documentation was found to support that the amount charged for the disputed services represents a fair and reasonable reimbursement for the services in dispute.
  - The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____ Signature	_____ <b>Grayson Richardson</b> Medical Fee Dispute Resolution Officer	_____ <b>October 28, 2011</b> Date
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### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**